RHODE ISLAND MEDICAL JOURNAL

MARCH, 1954

UNIFORM PROCESSING OF INSURANCE CLAIMS

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The RHODE ISLAND MEDICAL JOURNAL

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVII MARCH, 1954 NO. 3

UNIFORM PROCESSING OF PREPAYMENT MEDICAL-SURGICAL CARE PLAN CLAIMS*

CHARLES L. FARRELL, M.D., D.M.D., PHAR.D.

The Author. *Charles L. Farrell, M.D., D.M.D., Phar.D., of Pawtucket, Rhode Island. Chairman, Health Insurance Committee, Rhode Island Medical Society; Member, Committee on Prepayment Plans, Council on Medical Service, American Medical Association; Member, Board of Directors, Hospital Service Corporation of Rhode Island and of Rhode Island Medical Society Physicians Service.*

Since the inception of medical care plans in Rhode Island Dr. Charles L. Farrell has been active in their implementation and he has discussed the various features of these plans with insurance executives, Blue Cross and Blue Shield officials, and he has personally made an intensive study of their modes of operation and their reasons for being. In his presentation below he wishes to make it clear that he does not express a personal philosophy, rather does he predicate his statements and conclusions on facts resulting from his long experience and study of insurance programs.

THE EDITOR

INSURANCE is a cushion against disaster and is designed to minimize a loss. It is not a complete protection. Comprehensive insurance is extremely costly; sometimes impossible to obtain. Disaster is the lot of mankind, and no man can be completely protected against it, nor adequately compensated for it.

When one buys life insurance, for example, he purchases a policy which has a definite "face value." Suppose it is $10,000.00 and he buys it at the age of 21. It may be either a whole life policy, or by letting the dividends accumulate, it may become an endowment at age 60. If he is a normal adult in good health the insurance company has a formula with which it can figure to a high degree of accuracy the risk it is taking in insuring him for this given number of dollars, at a given premium rate. It knows almost to a decimal point the percentage of persons who are going to die in a given year, and what the causes of death are going to be. It also knows the degree of risk it is assuming in having to pay the insurance either as a death benefit before maturity, or as an endowment policy at maturity.

On that actuarial basis then, it can afford to issue a specific policy guaranteeing a stated amount of money in the event that one either dies before the maturity date, or lives and pays premiums until the policy finally matures as an endowment. The only reason insurance companies can stay in business is that their actuarial studies permit them to make such forecasts.

My father was in the insurance business and in my early youth I became thoroughly indoctrinated in insurance and insurance principles. I have also been interested to note the ever increasing range of coverage which has developed in the last 35 or 40 years, and there are policies now available that it was not possible to write in the days of my early youth. Policies are available covering all sorts of conditions that could never have been covered 35 years ago. Rates can be actuarily sound only as experience is accumulated. It is the result of accumulated experience over the years which permits insurance companies to say with certainty what they can do in a given case, i.e., how much coverage, under what conditions, and for what rate.

In the realm of health and accident insurance, and more recently in surgical-medical care insurance, the companies do not as yet have the actuarial data to permit them to be as generous or as omnipotent in this type of coverage as they are in the field of life insurance. With the passage of time, however, benefits will increase and premiums decrease and many other features that are not now available will be added. There is no substitute for experience.

To return to life insurance for a moment, let us assume that one has bought a $10,000.00 policy and is paying $300.00 a year for it. In the event he dies his family will receive the amount stated on the face of the policy. This is the result of a promise to pay a given number of dollars (i.e., face value) in the event that the policy matures. He has bought dollars and cents "face value!"

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*Presented at a Staff Meeting, Roger Williams General Hospital, Providence, Rhode Island, October 30, 1953.

Health and Accident Insurance

When it comes to accident and health insurance, such is not the case. In accident-health policies one buys a "coverage" for either total or partial disability for a guaranteed number of weeks paying a certain number of dollars in the event that he is either partially or completely disabled. This too can be fairly accurately forecast by insurance companies because they have been in this business a fairly long time.

The insurance companies know, however, that this coverage can be excessive and that persons might carry more insurance than their monthly income and therefore find it profitable to feign or develop a "difficult-to-define" illness which would permit them to collect more money from the insurance company than their usual income from salary or wages. Therefore, in many instances, insurance companies will ask about the existence of other policies and in some instances refuse to issue coverage if the sum total of the other policies would allow the individual, if injured, to collect more than his usual income for the period.

Likewise in fire insurance, one cannot insure a home for more than it is worth and then collect the extra value, because insurance companies will prorate the loss between them and pay only the actual value of the house. If the loss is covered by more than one insurance company they will share the loss between them.

These types of plans, however, do not particularly concern us. We are more concerned with the coverage provided in the so-called Prepayment Medical-Surgical Care Plans such as Rhode Island Medical Society Physicians Service, the Rhode Island Plan sold by some insurance companies, and the straight old fashioned so-called "Standard" type of surgical-medical care plan sold directly to industry by insurance companies.

Prepayment Medical-Surgical Care Plans

Of the prepayment medical-surgical care plans, there are several types. The one we are most familiar with, of course, is the Rhode Island Medical Society Physicians Service which needs no description from me at this point. The second is "The Rhode Island Plan," similar to Physicians Service in operation and benefits, but sold by the insurance companies under supervision of the Society's Health Insurance Committee instead of the Directors of Physicians Service. Thirdly, there is the "Standard" type of coverage sold directly by insurance companies to industry without medical society approval or physician participation and carrying varying degrees of benefits depending upon the premium rate structure and other features. This is the type of plan which is productive of many misunderstandings on the part of both physician and patient as to the extent of coverage and the allocation of benefits.

Processing Claims

1. When claims are submitted to *Physicians Service* the physician is paid directly the fee charged—up to the limit of the fee listed in the schedule of indemnities.

2. The *Rhode Island Plan* is similar in operation to Physicians Service except that in processing these claims, doctors will have to be responsible personally for having the patient "assign" the benefits payable under the plan to the doctor. The Insurance Commissioner, and the insurance laws of the State, require that the beneficiary of a policy be the recipient of the benefits therein—unless he assigns them to another. Therefore, by law the insurance companies have to pay the beneficiary directly *unless* the doctor obtains an assignment form permitting the insurance company to pay the doctor instead of the patient. In the majority of companies under the "Rhode Island Plan" this assignment form is printed on, and made part of, the claim form, and should be filled out by the patient at the time the medical or surgical care is arranged for, or performed.

Blue Cross Hospital Service and Rhode Island Medical Society Physicians Service are not insurance companies. They are service organizations and, while under the jurisdiction of the Insurance Commissioner, they pay directly to the hospital or physician respectively as *"participants"* in the "Plans."

3. The insurance companies who sell independently to mills and other businesses a straight surgical-medical care policy of the standard types, not involving physician participation, frequently have no space on their insurance claim forms for the assignment of benefits. It is necessary, therefore, that the doctor present the patient an assignment blank which can be attached to the claim form. A description of this assignment form and its use will be discussed presently.

Benefits Provided

Now for a moment let us consider what these medical care plans actually offer. In contrast to a life insurance claim they do not offer a dollar and cents figure. There is no "face value." This is generally misunderstood by doctors and patients alike. Whereas the life insurance policy holds forth a definite "face value" in the event the policy matures, no such dollars and cents value is placed in the medical-surgical care plans. True, there is a "schedule of benefits" but that represents only the maximum possible allowances available to the insured individual, in the event that he suffers from any one of the contingencies so listed.

Insurance of this character is sold on a *reimbursement* basis. That is, the insurance contract provides that "the company agrees to pay an *amount equal to the fees actually charged* to the

subscriber, but *not to exceed* the maximum amount specified in the Schedule of Indemnities." The Schedule of Indemnities is different with each plan, except for Physicians Service and Rhode Island Plan. Commercial company plans vary in benefits depending directly on the premium charged. It is possible to buy a top limit of $125.00 or $225.00 or $300.00, and the fees set in the Schedule of Indemnities bear a direct relationship to the amount of premium paid for the coverage. Some plans pay $15.00 for a tonsillectomy. This does not mean that $15.00 is what the tonsillectomy is worth. It simply means that for the premium paid and the risks taken under the plan, that is all the company can afford to pay considering the likelihood of a tonsillectomy being done. This explains, therefore, why an operation is often charged as being inadequately indemnified. The inadequacy of payment stems from the fact that the loss ratio, or the frequency of claim, is going to be high in that particular type of surgery. If other factors cut the risk, such as a very large group of adult males in the contract—the benefits can be increased for the same or reduced premiums. Physicians Service charges a fixed rate of premium and, as a result, loses business to commercial carriers in the sale of insurance to a large industry with predominantly adult male workers, because the risk of loss in this group is considerably less than in a small plant with a high percentage of female workers. The insurance company adjusts the rate and therefore can offer the same benefits for a reduced premium.

Some of the policies examined in my office have shown a tendency to be very generous but when one reads the fine print he will find that the patient must sustain an accident to have some surgery done. We have seen some plans wherein surgery would be paid for if it was done as result of, or coincident with an accident which the patient suffered. Under the circumstances it would not be likely to happen very often to the ordinary individual and the premium rate of such plans is correspondingly very low.

Physician Participation

Participating physicians in the Rhode Island Plan, and those participating in Physicians Service Plan, have agreed that they will accept as full payment for the surgical operation, reduction of fracture, administration of anesthesia, or medical care after the third day in the hospital—the limits provided in the policies of these two plans, except where the subscriber is *"entitled to receive benefits from the same or similar source or from some other source."* Benefits under these contracts therefore, apply as an indemnity if the patient has additional coverage.

In an attempt to take the financial sting out of the surgical-medical care costs the physicians in Rhode Island have agreed to accept *less* than their customarily accepted fee for their services, on the condition that the patient has limited resources, and is unable to pay the usual fee. If, however, the patient has extra resources—insurance or otherwise—then the physician is relieved from his obligation to accept only the fee provided in one or more of these plans, and can morally and legally adjust his fee to the resources of the patient—considering the sum total of benefits available from insurance sources.

Double Coverage

The greatest cause of misunderstanding in the use of these plans is when "double" coverage and occasionally "excess" coverage results. By double coverage we mean where husband and wife are both employed and are both insured at their respective places of employment. Under any circumstances of multiple employment their income is conceivably over $3600.00 a year as a family group and they are not eligible for service benefits—even if they do not have two insurance plans. However, in most instances they *do* have two insurance plans. It is quite likely that one member of the family is employed where Physicians Service coverage is in effect, and the other member is employed where a commercial plan is in effect.

Before going into details, let me state categorically here and now that if both husband and wife are employed at different plants and each is covered by separate Physicians Service benefit programs, the Physicians Service will pay up to the full amount on two coverages. If Mrs. A has her appendix out and she is insured by Physicians Service, and Mr. A is insured by Physicians Service in another contract in a separate place of employment, there is up to $200.00 available for payment to the surgeon as one subscriber is a dependent of the other, whereas if only one were covered by Physicians Service, the total amount available for appendectomy would be $100.00.

Again, it is important to remind you at this point that the benefits under Physicians Service are also *limited* by contract and the Physicians Service will pay "an amount equal to *fees actually charged* to subscriber up to the maximum amounts specified in part VIII of the Master Schedule"—etc. In other words, if the surgeon should charge only $75.00 for an appendectomy that is all Physicians plan (or any other insurance plan) would pay or would be legally required to pay; and that would be the full extent of the benefit to the subscriber because the obligation to pay $100.00 is not automatic. In other words, when an appendix is removed there is no stated amount automatically available to the surgeon. If he charges less than the maximum, the Physicians Service or any other insurance company is obligated to pay only the amount of the bill—but under no circumstances can they pay beyond the

continued on next page

maximum. This is equally true of all types of commercial carriers.

The difficulty in adjudicating claims stems from the fact the "Schedule of Indemnities" as published are misunderstood to be Fee Schedules. Such is not the case! This list represents only the list of maximum possible benefits that can be paid under any circumstances.

In many instances Physicians Service hopes that it will not be billed for the entire amount available. For example, if the patient comes to the office and has a small abscess opened and drained, the maximum benefit payable under the plan is $10.00. If, however, the surgeon is accustomed to doing such a procedure for less than $10.00 in his office and would charge the patient less if he didn't have insurance coverage, then Physicians Service should expect to be billed for the usual fee of the surgeon. It does not expect to be billed for $10.00 just because there is a maximum $10.00 listed in the Schedule as "available." In the event, however, that the surgeon wanted to charge $20.00, Physicians Service could pay only as high as $10.00—the balance, whether it is paid or not would be determined by the patient's eligibility for service benefits.

Let us turn for a moment to the consideration of the case where Mrs. A. is insured at her place of employment through a commercial plan and Mr. A. is insured with Physicians Service at his place of employment. In the event that Mrs. A. has her appendix out, Physicians Service will pay $100.00 directly to Dr. B. for performing the operation because Mrs. A. is a dependent of her husband and is therefore covered under Physicians Service. When the time comes for Mrs. A. to produce proof of her surgery to the insurance company at her place of employment, she will receive a claim form which she brings to her physician, Dr. B. If it is the "Rhode Island Plan" claim there will be a place on the claim form for her to assign the benefits to the physician. This should be required by the physician, prior to the completion of the form, so that reimbursement by the insurance company may be properly channeled as was intended when the insurance was written. In the event, however, that Mrs. A. is employed at a mill where the commercial carrier is not a member of the Rhode Island Plan, her claim form will not provide a place for assignment to the physician and therefore the assignment form put out by the Health Insurance Committee of the Rhode Island Medical Society should be used. This form should be completely filled out, signed by the patient and attached by gummed sticker securely to the insurance form. The completion of this form should be required by the physician before the completion of his part of the claim form, and as a prerequisite thereto.

The reason for applying the assignment form securely to the claim is that in many instances when these claims are processed at the mill the employee handling the claim tears off the loosely applied, or incompletely applied, assignment form on the theory that the money belongs to the patient and not the doctor. The employee desires to ingratiate himself with the patient by diverting the fund directly to the patient instead of to the doctor.

This is entirely improper, inasmuch as the patient — though the legal beneficiary — is morally bound to use this payment for the physician's services as its receipt is predicated on the services of his physician.

In several instances the patients have had the mistaken notion that the money thus collected from insurance companies is theirs as a benefit to them, rather than as a means to help pay the cost of their surgery or medical care.

No patient can make a profit on his physician's services! No one should make a profit on the work of the physician's hands or brain, and if the patient has excess coverage above and beyond the usually accepted or mutually-agreed-upon fee for the work, there is no justification whatsoever for the balance to be turned over to the patient.

In the event the coverage is in excess of the usual or customarily accepted fee, the excess can be applied to the pre- or post-operative care which is ordinarily not covered, or the insurance plans can be prorated. In other words, if a doctor knows in advance that he is going to get $100.00 from Physicians Service and $100.00 from another source of insurance and he is satisfied with a fee of $150.00, then fees should be prorated between the two insurers. The Physicians Service and the other carrier should each be billed $75.00.

In many instances the combined fee of both plans more nearly approximates the correct fee and there is no question that the surgeon or physician is entitled to payment from both plans. Schedules of Indemnities are usually well below the customarily accepted fee for the services performed. No physician should expect the plans to pay in excess any more than he would expect the patient to do so. But if there is no way to prorate the fees and excess payment results, it may be properly applied to patient-care but not to the patient's pocket.

Because of misunderstandings and the inability of the sick patient and his family to appreciate the fine points of the insurance problem, it is relatively impossible to explain adequately the situation to them in detail unless they have had some firsthand experience with insurance procedures. Therefore the following procedure is recommended as standard practice and if doctors will develop it as routine office business practice in dealing with patients using prepayment medical-surgical care plans, the misunderstandings will be minimized and claim

procedures so expedited as to attain general acceptance. If, however, a concerted plan of action is not followed, it will result in chaotic conditions with erroneous ideas becoming so firmly fixed and prevalent that in a few years it will be difficult, if not impossible, to correct them.

Recommended Uniform Procedures

1. When arrangements for hospitalization are discussed, inquire if the patient has insurance coverage and the extent of such coverage. The physicians' and surgeons' fees should *not* be predicated on the amount of insurance coverage available. Nevertheless, the patient should not be quoted fees predicated on the patient's limited coverage *if* he has adequate coverage to pay an acceptable fee. If the patient is vague regarding the extent of his insurance or the type of insurance, ask him to bring in the policy and to ascertain the type of insurance available.

Explain to the patient that it may be possible that the insurance coverage he has is adequate, and in some instances, more than adequate. If he raises the question as to its adequacy, it should be further explained that in the event he knows exactly what the coverage is—or the policies he produces definitely describe such coverage—the claims can be prorated between the insurers if it is in excess of the customary fee. In most cases, however, it will not be in excess and will probably not even equal a proper fee. In any event it should be clearly explained to the patient that insurance programs are predicated on the *reimbursement* principle, i.e., the patient is to be *reimbursed* for the *actual financial loss suffered* and if the benefits are in excess of financial loss, no financial gain may accrue to the patient from the services of his physician. We should have no hesitancy in stating to the patients that we do not propose to take advantage of them, but they likewise are not to profit financially from the use of our services. It should be possible to face this problem with honor and dignity.

2. Inform patients that when filing claims for medical-surgical benefit it will be necessary to assign those claims directly to the physician or surgeon involved, and that when the claims are paid the account will be properly credited. An assignment form prepared and supplied by the Rhode Island Medical Society should be attached by gummed sticker to the claim form.

3. Require that all claim forms presented be completely filled out before being submitted to the physician, who will then validate the claim by his signature and direct mailing to the company office of the employee. *This is important.* Require all forms to state clearly the type of coverage provided. In many instances employers will object to such procedure and it is not fair to subject the patient to argument with his employer. Therefore in such cases claim forms should be mailed by the physician to the employer with an accompanying letter stating that it is the policy of the Society to require the form to be completely filled out before being validated by the physician. In no instances have employers refused to cooperate on this basis.

4. Bills should not be sent to insurance companies unless specifically requested and should be attached by gummed sticker to the original claim form. State on the claim form the exact amount the insurance company is to pay in that particular case. Remember, this insurance is on a reimbursement basis. Duplicate or multiple bills should *not* be issued.

Finally, in order for a patient to collect on insurance policies he must have a claim form signed by the physician. If physicians withhold signing these claim forms until they are completely filled out, and the authorization for assignment has been attached, there should be no difficulties. Patients can make a profit on the doctors' services only with the cooperation of the doctors themselves.

The patient who refuses to sign an assignment form, or refuses to allow his physician or surgeon to obtain a guarantee of direct payment for his services, usually has an ulterior motive by which he hopes to profit in his own manipulation of the claim.

The instructions available through the medical Society are for distribution to the patients, explaining the situation clearly, and the assignment forms supplied are gummed so that they may be securely attached to the insurance claim form. If every physician will follow these simple steps the problem of duplicate coverage and extra coverage will soon dissolve because insurance companies will not sell, nor will patients buy, coverage in excess of their legitimate needs when the doctors require coverage only to meet such legitimate demands.

SAVE THE DATES—

May 5 and 6

THE USES OF ERYTHROMYCIN IN DERMATOLOGY

WILLIAM B. COHEN, M.D.

The Author. *William B. Cohen, M.D., of Providence, Rhode Island. Chief Dermatologist, Memorial Hospital, Pawtucket, and at Miriam Hospital, Providence; Consulting Dermatologist, Veterans Hospital, Providence.*

I FULLY REALIZE that the advent of new drugs and their therapeutic evaluation are a constant challenge to every physician. One must be alerted and encouraged to use the most appropriate drug in each case.

Every physician acknowledges and appreciates the great values of such antibiotic drugs as Sulfas, Penicillin, Aureomycin, Terramycin, but each one has its own limitations. It is my purpose to discuss a drug that can eliminate some of the unfavorable reactions of previous antibiotics.

Erythromycin is produced by an organism which was originally isolated from a soil sample collected in the Philippines and identified on the basis of its morphology, cultural characteristics, and physiology as a strain of Streptomyces Erythreus. Preliminary studies indicate that it has a specific field of usefulness in the treatment of infections and may serve in the place of other commonly used antibiotics under special circumstances. The trade names of this new product are Ilotycin and Erythrocin. And like other antibiotics it is available in tablet, powder, liquid, and ointment forms.

Among its specific attributes are: success over infections produced by Staphylocci, Streptococci, and Pheumocci, and particular merit in the treatment of conditions caused by Gram Positive organisms which have been resistant to the action of Penicillin and other antibiotics. The dermatologist is concerned most with such organisms as Staphylocci, Streptococci, and Pseudo Aeruginosa or Bacilus Pyocyaneus in his everyday routine, and this drug is recommended for the treatment of the same. Thus, since its release in November, 1952, I have been using it with considerable success.

The cases I have selected to discuss are from the Rhode Island Hospital, and the Pawtucket Memorial Hospital Skin Clinics and from my own practice.

Cases

1. Patient: L.D., male, white, 15 years old.

Date: November 19, 1952.

Place: Rhode Island Hospital Skin Clinic and privately.

Diagnosis: Acne vulgaris with severe generalized furuncolosis.

History: In November of 1952, this patient was referred to the clinic by his local physician who had been treating him over a four-month period with Penicillin injections once-twice weekly. The clinic treatment began with topical remedies and Penicillin injections every other day.

When I was confronted by this patient covered profusely by unsightly furuncles of varying sizes on his face, neck, chest, and back he was in a sad state emotionally as well as physically as his appearance had shamed him into leaving school and he had lost fifteen pounds. Furthermore, the discomfort was so acute that he could not bear the weight of his clothing, thus necessitating a daily afternoon rest in bed. Since all other treatment had failed, I was convinced the case warranted a try with Erythromycin.

First dosage: December 1, 1952, 100 mg. every six hours for one week.

Progress: There was decided improvement following the initial dosage.

Second dosage: December 8, 300 mg. every four hours for two weeks.

Progress: There was more improvement after the increased dosage in that the furuncles broke open and drained without surgical aid and without any difficulty to the patient. Treatment was discontinued on December 15 to check effects. There was a relapse.

Third dosage: December 23, 100 mg. every four hours.

Progress: No further improvement.

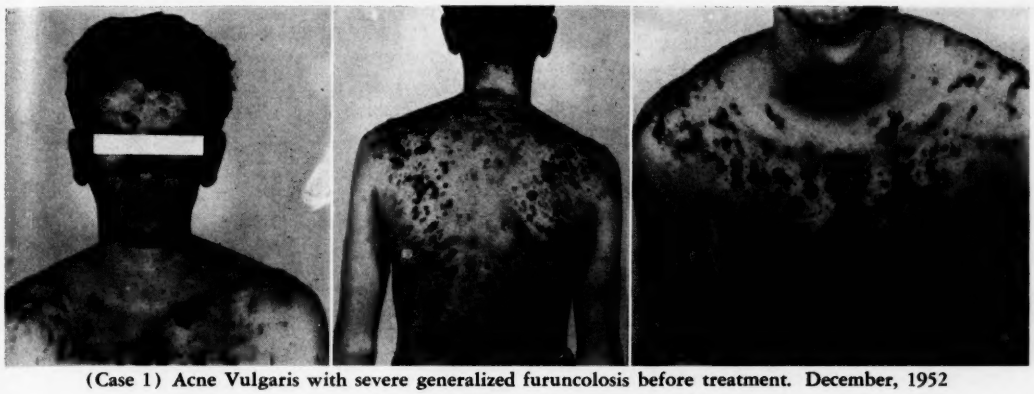
Fourth dosage: December 30, 200 mg. every four hours.

Progress: Definite improvement.

Fifth dosage: January 13, 1953, 300 mg. every four hours for two weeks.

Progress: Marked improvement. No treatment administered from January 27 to March 10. Slight recurrence.

Sixth dosage: March 10, 200 mg. every four hours for four weeks.



(Case 1) Acne Vulgaris with severe generalized furuncolosis before treatment. December, 1952

Progress: Marked progress. No treatment from April 7 to July 17. At this last date the patient visited my office for general observation and there was decided improvement in the entire skin texture. The scarring was diminishing and there were only occasional furuncles.

Remarks: Work with this patient was facilitated by private study from December, 1952 on, when I went off hospital service. This treatment is not indicated in regular cases of Acne Vulgaris.

2. Patient: E.C., male, white, 15 years old.

Date: July 31, 1953.

Place: Private patient.

Diagnosis: Acne vulgaris with severe generalized furuncolosis.

History: June 22, 1953, this patient was operated on for fistula in ano and was hospitalized for 10 days. Following the operation there was considerable drainage and he walked with great difficulty.

First dosage: On July 31, 1953, Erythromycin 100 mg. every four hours was prescribed.

Progress: The drainage stopped, and the patient could walk without difficulty.

Second dosage: On August 6, 1953, the dosage was raised to 200 mg. every four hours. This dosage continued until September 4.

Progress: Most of the pustular lesions broke down and began to drain. Crust formed over the lesions. The patient observed that his friends noted the marked improvement of his complexion.

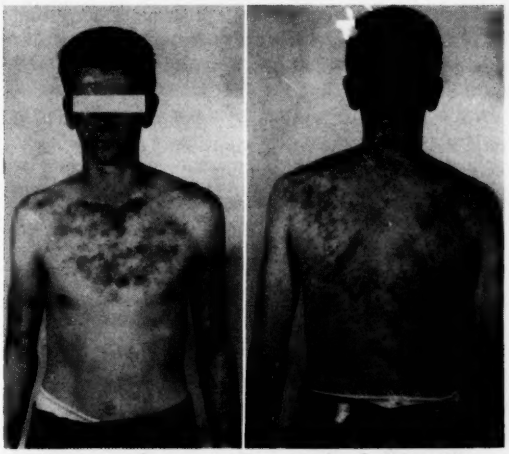
Third dosage; On September 4, 1953, the dosage was raised to 300 mg. every four hours to counteract a few stubborn lesions. The patient remained on this dosage until September 26.

Progress: There was marked improvement.

Fourth dosage: 200 mg. every four hours on September 26.

Progress: Treatment was discontinued on October 15. No new lesions had developed. Those remaining are crusted and are clearing up.

Remarks: In this type of case there is considerable scarring because the lesions are deep-seated.



(Case 1) After treatment. Completed. July, 1953

3. Patient: T.B., female, white, 30 years old. Graduate nurse employed in industrial nursing.

Date: April 20th, 1952.

Place: Private patient.

Diagnosis: Paronychia of the right second finger with extensive pustular dermatitis involving both hands.

History: Previous to her first visit the paronychia had been incised by another physician on April 11. She had also received two injections of Penicillin with no results.

First dosage: April 20, 100 mg. every six hours for 3 days.

Progress: No improvement.

Second dosage: April 23, 300 mg. every four hours for four days.

Progress: Great improvement. However, due to the expense involved in this treatment (thirty cents per tablet of 100 mg.), the patient stopped treatment causing a relapse.

Third dosage: May 2, 300 mg. every four hours.

Progress: By May 7, the infection was cleared up. The occupational dermatitis was treated subsequently.

continued on next page

Remarks: A substantial dosage was needed to produce the desired results. Note Penicillin failure.

4. Patient: C.R., female, white, 47 years old.

Date: October 19, 1953—this patient was admitted to the hospital.

Place: Pawtucket Memorial Hospital.

Diagnosis: Contact dermatitis with a secondary infection involving the face, hands, arms, and legs.

History: Previous to hospitalization the condition was treated by a local physician. As it progressed the physician referred the patient to the hospital. The eruption began on the hands and spread to other areas.

Description: The patient's face was red, swollen, covered with crust, and both hands and arms were swollen. The hands had large pustular lesions, and on both arms there were erythematous vesicular crusted patches. She ran a temperature of 99.8 upon admission.

First dosage: October 22, 1953, I prescribed boric acid soaks, vioform ointment, and Erythromycin, 200 mg. every four hours.

Progress: Slight improvement.

Second dosage: October 24, Erythromycin increased to 300 mg. every four hours.

Progress: Decided improvement.

Third dosage: 200 mg. every four hours.

Progress: Good progress.

Fourth dosage: October 27 the Erythromycin was discontinued.

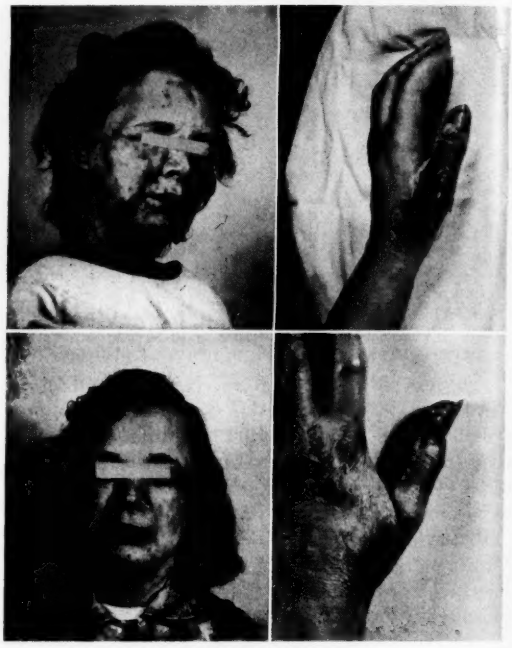
Progress: The patient was discharged on October 29, 1953.

Remarks: Most of the eruption had cleared. The patient was referred to her local M.D. for follow-up treatment.

Of the fifty cases in which I have used Erythromycin the diagnoses ranged from folliculitis, impetigo, acne vulgaris with marked secondary infection, chronic atopic dermatitis with secondary infection, and many contact dermatitis cases with secondary infections. Dosage varied of course, with the individual cases; it was largely a trial and error process due to the newness of the drug. Moreover, in some instances progress was limited or halted because it was so costly for the patients. *But in no case was there any reaction to the drug itself.* Systemic antibiotic therapy is more rapid and consistently more effective than the topical. Furthermore, since infection of the skin is infection of the body, systemic treatment is indicated because it protects against the possibility of serious visceral involvement.

I had the good fortune of being presented with a considerable amount of Erythromycin ointment 1% by the Abbott Co. I used it in the following

(Case 4) Contact Dermatitis with secondary infection, before treatment



(Case 4) After treatment

types of cases: (1) impetigo contagiosa, 15 cases; (2) ecthyma, 5 cases; (3) folliculitis of the beard and other areas, 6 cases; (4) atopic dermatitis with secondary infection, 8 cases; (5) ulcers, 4 cases; (6) contact dermatitis with secondary infection, 12 cases.

Cases

5. Patient: D.L., male, white, two weeks old.

Date: April 21, 1953.

Place: Private.

Diagnosis: Bullous impetigo generalized.

History: This baby was under the care of a local physician who diagnosed his condition as a feeding-allergy problem and prescribed a restricted diet.

First visit: April 21. Erythromycin ointment applied.

Second visit: April 23. Decided improvement. The child was on a normal diet. By April 25 the condition was cleared.

In evaluating the findings in the above cases, I have found the ointment to be most effective. The average case responded between 5-7 days. It does not irritate or sensitize the skin such as Penicillin or sulfa ointments.

In closing I want to emphasize the following: Erythromycin definitely has a place in the antibiotic field as it can be employed safely without fear of any unfavorable reactions. Moreover, I feel, it is the choice antibiotic in dermatology.

THE PRACTICAL MANAGEMENT OF HEADACHE AND OTHER HEAD PAINS

DAVID J. LAFIA, M.D.

The Author. *David J. LaFia, M.D., of Providence, Rhode Island. Assistant Surgeon, Department of Neurosurgery, Miriam Hospital; Visiting Neurosurgeon, St. Joseph's and Roger Williams General Hospitals; Consultant in Neurosurgery, Woonsocket Hospital.*

TO IMPART practical information useful in the management of pain and its problems is the purpose of this paper. There is no room here for philosophical palaver on the meaning of pain or of the many theories to explain the mechanics of its perception. Nor is it necessary to delay on a definition. Suffice it to say, that pain is the most common *symptom* of which patients complain and perhaps the principal reason for the existence of the art of medicine. It is almost a truism that man is born into this world in pain and most of the time leaves it in pain.

A review of the bare facts of the anatomical basis for pain perception is perhaps the best starting point. To perceive pain we must assume the integrity of the neuraxis from the brain to the spinal cord and its peripheral nerves. The central nervous system is divided into brain and spinal cord. The former is further broken down into cerebral hemispheres, cerebellum, brain stem with its diencephalon, mesencephalon, pons and medulla.

The cerebral hemispheres are divided into frontal, parietal, occipital and temporal lobes. In the postrolandic area of the parietal lobes pain messages are received and then relayed to the various parts of the cortex. This is perhaps the highest level of integration. The diencephalon is the next level of pain perception integrity. Its nuclei act as a relay center for pain impulses from every part of the body before they are projected into the various cortical areas. Certain whitetracks in the spinal cord and brain stem carry messages of pain and temperature perception from the arms, legs and trunk to the diencephalon. An important point is the crossing over of pain fibers from the site of reception of impulses to the opposite side of the spinal cord and brain. For example, pain stimuli coming in the right side of the body are registered in the left half of the neuraxis, and to relieve pain in the right leg, it would be necessary to section the anterolateral white column of the spinal cord on the left side. The fifth cranial nerve carries sensation in the face and head to the brain stem. Visceral pain is transmitted chiefly by the autonomic nervous system.

Before discussing the approach to the patient with pain, what about the mechanism of pain? Its nature still baffles us. To call it a response to a harmful stimulus puts some meaning into human suffering. This stimulus can be external or internal. When of the first kind we think of trauma or infection on the surface of the body: local swelling caused by hemorrhage or edema of an inflamed region irritates nerve fibers, so causing pain.

Internal causes of pain have much the same mechanism: either a neoplasm pressing on sensitive nerve fibers or with distention of blood vessels such as in the brain, cause head pain, or a gallstone in the common duct producing distention with pain referred to the right upper quadrant.

The possibility of a chemical substance released at the site of injury that is carried to the brain as a cause of pain has never been demonstrated. As for the emotions, their effects may be primary or secondary and will not be discussed here.

When all is said and done, pain exists and its causes are not clearly explainable. Now for the management of the patient with pain.

We can take up pain in two large areas of the body: (1) The head. (2) Limbs and trunk. This paper will be limited to headache and other head pains. And these two conditions are not the same.

Headache can be caused by extra-cranial and intra-cranial lesions. Operations done under local anesthesia, have shown that the pain-bearing structures of the head are blood vessels and dura. Distention of the superficial temporal artery, for example, causes sharp pounding pain along the side of the head. Stretching of intracranial blood vessels such as the middle meningeal artery or the artery along the base of the brain likewise causes pain that will radiate into either the frontal or occipital or temporal areas, depending on the location of the stimulus. Stretching of the dura at the tentorium or the falx likewise causes pain referred to the vertex or frontal or occipital areas. Though paradoxical, irritation of the brain itself is painless.

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The trigeminal nerve is the great sensory nerve of the head. Its branches cover the three areas of the face: ophthalmic, maxillary and mandibular.

At this point let's turn to "head pain." Trigeminal neuralgia or tic douloureux is characterized by lightning-like pain in the distribution of one or more divisions of the trigeminal nerve. These are paroxysmal, often triggered by chewing, rubbing the face or placing the tongue in a part of the mouth. Its cause still eludes us. In an attack the patient suffers horribly and writhes in pain, his face grimaced. Duration may be seconds to several minutes. It can be so severe that cases of suicide have been recorded. The most consistent part of the picture is (1) the pain always followed the area of cutaneous distribution of the trigeminal nerve, (2) there are no demonstrable abnormal neurologic findings such as hypesthesia. When a patient complains of facial pain that migrates from one side to the other, sometimes in the forehead, sometimes in the mandibular area, lasting many minutes or hours or days, diagnosis is not trigeminal neuralgia but an atypical facial neuralgia. The findings of corneal hypesthesia or facial hypesthesia suggest a compressive lesion of the gasserian ganglion. Add to these findings tinnitus and tumor of the cerebellopontine angle becomes more than probable.

So much for neuralgia of the face. Pain in the throat may be glossopharyngeal neuralgia; more rarely pain "streaming out the external auditory meatus" points to neuralgia of the intermedius branch of the seventh cranial nerve. In such neuralgias, resection intracranially of the appropriate nerve gives permanent relief. In the case of trigeminal neuralgia, alcohol block of the second or third division or avulsion of the supraorbital or infraorbital nerve can be temporarily effective. Analgesics have generally failed to relieve trigeminal pain and even morphine fails. Of course, all patients with persistent facial pain must be thoroughly examined to remove such causes as carcinoma of the face, mouth, tongue or nasopharynx; intracranial tumors compressing the fifth, seventh or ninth cranial nerves. In such instances combined resections of the fifth, ninth cranial nerves and upper cervical sensory roots can be a blessing.

To get back to headache. Like pain elsewhere in the body, it may be the signal for more serious disease. Any patient complaining of headache over a long period of time, demands a further investigation. Basic to such a check is a simple neurologic examination that includes first and foremost funduscopic and visual field studies. These take but a few minutes and give a mine of information. Reflexes and other tests complete such an examination. It is not necessary to go into the great detail of the expert neurologist to become suspicious of a space-occupying lesion* as the cause of the patient's headache.

The classical triad of headaches, vomiting and choked discs indicating a brain tumor are late signs. To supplement the basic neurologic examination, an x-ray of the skull must be made. Decalcification of the sella turcica or a pineal shift, or abnormal calcification are cogent clues to intracranial disease as a cause of headaches. The electroencephalogram has become an effective and useful adjunct to the study of patients with headaches suspicious of intracranial disease. But it still carries a high margin of error.

Previously we mentioned the distention of intracranial blood vessels as the cause of headaches and perhaps the most common type of headache seen in the practitioner's office is the vascular or tension headache. The ultimate cause of this is still a mystery. We know that headaches are commonly experienced under tension states or other emotional pressures. Fatigue and anxiety predisposes to headaches indirectly through distention of blood vessels. The migraine syndrome is the most severe vascular type headache. Contrary to the literal definition that migraine is pain in one-half of the head, the word being a contraction of hemicrania, it is more accurately pain in one side of the head that shifts to the entire head and is not always confined on repeated attacks to the same side of the head. Migraine is characterized often by warning and a building up of the pain to such intensity that nausea, vomiting, pounding, pain in the eye follow in the wake of the initial onset of pain. During the height of an attack, certain patients experience scotomata, others, paresthesiae into one or more limbs. Here the vascular mechanism consists of distention and vasospasm. It is believed at first there is a sharp wave of vaso-spasm and then reflex dilatation of the artery.

In the treatment of migraine, prevention is the best we can offer by the use of ergotamine tartrate preparations. At the onset of pain, Cafergot® orally in adequate doses can abort the pain. Once the pain rages then only sleep, a strong sedative such as phenobarbital and even codeine by injection may be necessary. When migraine is unilateral or starts in middle age, intracranial aneurysm must be considered and cerebral angiography performed.

In the practical management of patients with headaches, careful histories, eliciting the response to emotional states, indigestion or malaise and especially a familial tendency to headaches must be carefully searched for. Of course, vascular hyper-

*This phrase refers to expanding intracranial lesions like brain tumor, abscess, hematoma and the like.

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THE VOLUNTARY WAY IS THE AMERICAN WAY*

JOSEPH C. O'CONNELL, M.D.

The Author. *Joseph C. O'Connell, M.D., President of the Rhode Island Medical Society Physicians Service.*

"The best way for most of our people to provide themselves the resources to obtain good medical care is to participate in voluntary health insurance plans."

DWIGHT D. EISENHOWER, President of the United States, in his special message to Congress, January 18, 1954.

THE Rhode Island Medical Society Physicians Service, incorporated in 1949, enrolled its first subscribers effective January 1, 1950, thereby offering to the people of this state the opportunity to purchase low cost surgical-medical care insurance sponsored directly by the medical profession. This action was an extension of the proposals made three years before by the Society through its invitation to all insurance companies to participate in a program "to increase the extent to which voluntary insurance against the cost of medical care is made available to the people of Rhode Island."

Physicians willingly subscribed to participation in the Physicians Service benefit program and today more than 90% of the active practicing physicians in Rhode Island have signed agreements that provide in part that the

> physician will render professional services in accordance with the agreement from time to time in force between Physicians Service and its subscribers, to those subscribers accepted by him as patients, and that he will accept the amounts specified therein (*or such lesser amount as may be deemed necessary by the Board of Directors of Physicians Service to maintain its financial integrity*) in full for services rendered to subscribers entitled to service benefits under said agreement, and as partial payment in all other cases as provided therein.

This voluntary participation by the overwhelming majority of the physicians of Rhode Island has undoubtedly been the greatest single factor in making Physicians Service the country's outstanding voluntary health insurance program sponsored by a state medical society.

In the short span of four years we have enrolled over 400,000 subscribers, an estimated 50.5% of the state's population. Statistically the Rhode Island Medical Society Physicians Service ranks second in the country in percentage of population enrolled, with the Delaware plan in first place with 64% of its population covered. However, it is significant to point out that our plan has already enrolled 80,000 more persons than there are in the entire state of Delaware.

One of the major criticisms of surgical-medical programs has been the inability of the individual self-employer or the individual unemployed to secure coverage. For three years, however, Physicians Service has conducted an annual enrollment, widely publicized by press and radio to permit anyone in the state of Rhode Island to purchase surgical-medical coverage. The response of the people to the opportunity to support the voluntary way—the American way—has been most gratifying and encouraging.

The direct enrollment campaign in 1953 added 15,892 additional subscribers to our total of whom approximately eighteen hundred were over 65 years of age. This represents a notable addition to the social security program of these individuals, and it is a tribute to Physicians Service that it has taken national leadership in sponsoring enrollment for any person, with no age limit, employed or unemployed.

Our plan is rapidly reaching a leveling-off stage when our enrollment will increase very slowly, and when we shall have to evaluate all phases of our services to determine how they may be improved for the benefit of the subscriber and in fairness to the participating physicians who underwrite the entire plan. The Schedule of Indemnities, drafted on the basis of a fee schedule developed ten years ago, with indemnities in many instances scaled below the then prevailing charges in our communities, is undoubtedly the one price list in our whole area that has not moved upward with the inflation of the times. In order that the subscriber may receive a more liberal indemnity and the physician a more equitable fee predicated on today's cost of living, it is hoped that some revisions may be effected in 1954.

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*Presented at the Fifth Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service, at Providence, January 20, 1954.

Secondly, we undoubtedly will have to continue studies aimed towards an extension of benefits to meet the needs of the people in providing their required health coverage. The rising cost of hospitalization has been reflected in two additional premium charges by the hospitalization plan during a period when no increase has been made in the surgical-medical premium, and if we are to augment our services to provide greater medical coverage, possibly radiological benefits, and coverage in catastrophic illness of long duration, we must increase the premium charge. Many beneficiaries of Physicians Service have written to me in the past two years expressing the hope that we will augment our services and these people have indicated that they, and in their opinion most other subscribers, would gladly accept the necessary premium increase to make possible such extensions.

To your Board of Directors who have given very liberally of their time and talents during the past year a great appreciation is due. Not only have they met regularly for long business sessions to review matters encompassing the entire program, they have also served as members of special committees — on claims, on professional problems, finance, and on executive matters. We are particularly in debt to our non-medical members of the Board who have brought to our planning a keen insight of business and financial experience that has contributed greatly to the benefit of the subscribers.

To make Physicians Service the second in the country in percentage of population enrolled was a selling job that has been done very effectively by our administrative officers, and on the occasion of this, our fifth annual corporation meeting, I express our thanks to them for their valued and loyal service in promoting surgical-medical coverage as effectively as they had previously advanced hospitalization coverage.

PHYSICIANS SERVICE ELECTS

Dr. Joseph C. O'Connell, of Providence, was re-elected for his fifth term as president of the Rhode Island Medical Society Physicians Service by the Board of Directors of that organization at its annual meeting. Other officers elected were Dr. Rocco Abbate of Lakewood, vice-president; Dr. Ernest K. Landsteiner, secretary; and Dr. Charles J. Ashworth, treasurer.

John J. Halloran, commercial superintendent of the New England Telephone & Telegraph Company, was elected as a new member of the Board to serve during 1954. Other representatives of the public re-elected were Walter F. Farrell, president of the Providence Union National Bank and Trust Company; George R. Ramsbottom of Pawtucket, president of the Seekonk Lace Company; Felix A. Mirando, secretary-treasurer of the Imperial Knife Company; Emil E. Fachon, president of the Bulova Watch Company; and James R. Donnelly, manager of the Pawtucket Branch of the Hospital Trust Company.

THE PRACTICAL MANAGEMENT OF HEADACHE AND OTHER HEAD PAINS

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tension must have been ruled out. A basic workup is incomplete without the neurologic examination and skull x-rays. If necessary, even further studies done by a neurosurgeon such as cerebral angiography, pneumoencephalography complete the picture. Such studies will eliminate demonstrable organic lesions otherwise overlooked.

Finally a rational treatment can be outlined. First the patient is reassured by the thorough workup that serious disease has been ruled out. Judicious use of sedatives and analgesics can be advised. Without delving into the nebulae of psychologic disease, we must admit that headache can be a symbol, for many patients, of indecision and anxiety that bedevils their subconsciousness. An understanding, sympathetic physician can do much to treat effectively such patients. For many patients suffer needless anxiety because of friends or relatives who have had headaches and later turned out to harbor brain tumors or vascular abnormalities.

The basic approach in summary to the patient with headache includes: (1) Thorough history. (2) Neurologic examination with funduscopic and visual field test. (3) Skull, sinus and cervical spine x-rays. (4) Expert opinion before proceeding to lumbar puncture. (5) Neurosurgical diagnostic studies as indicated: pneumoencephalography and/or cerebral arteriography. (6) Help of a competent psychiatrist when simple reassurance and ordinary measures fail. Only by a thorough circumspective workup such as this can the occasional patient with a space-occupying lesion be diagnosed instead of missed by deferring expectant therapies.

143d ANNUAL MEETING

May 5 and 6

The RHODE ISLAND MEDICAL JOURNAL

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106 Francis Street, Providence, Rhode Island

LIBRARIES AND HUMAN FRAILTIES

WE HAVE just received a copy of the new regulations for the use of the library in the Peters' House at the Rhode Island Hospital. This library has found, as have many other such libraries; those of medical schools for instance, that it has to be carefully supervised if it is to avoid heavy losses. It is a wonderful thing to give ardent young medical students free access to the literature. Unfortunately there are always a few who make this almost impossible. The type of doctor who drives into a parking area which is bound to be filled later and carelessly leaves his car at an angle that uses up three spaces; will pick up the latest periodical, leave it on his desk and very possibly thoughtlessly push it into the wastebasket. It is unfortunate that heavy restrictions have to be placed on everybody to keep this man in control.

The daily press never allows us to forget that there are in medical ranks, as in any large group, certain individuals who are bad actors. It is, of course, impossible to defeat the ends of these altogether.

Our own library suffers little from this type of thing; we have to admit that this is because of strict supervision. We do have our troubles, however. We will confide in you and tell you that there are borrowed books out even now that have been out for years. The careful supervision and indefatigable efforts of our librarian really make such cases few in number.

Our MEDICAL JOURNAL gets many excellent books for review. We have made it a rule, which is cheerfully agreed to in almost every case, that these books shall be the property of the library. Rarely does any one man keep any one book in frequent use, so this constitutes the greatest good to the greatest number.

The JOURNAL is proud of the record it has made with book reviews. A man should be flattered when we ask him to review a book. We don't turn them over to every Tom, Dick, and Harry. As all reviews are signed the reviewers have at least one reward—they get credit for a good piece of work. Occasionally it is difficult to get the review returned with reasonable promptness and once in a great while we cannot get the book back. If you, dear reader, receive a book for a review, try to collaborate with us.

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INSURANCE CLAIMS

With Physicians Service now one of the most successful insurance programs of its type in the country as regards percentage of population enrolled, as noted elsewhere in this issue, and with insurance companies adding another 33,000 persons under the Rhode Island Plan, plus their coverage under standard contracts, the matter of insurance claims takes on special significance for physicians.

The article on uniform processing of insurance claims published in this issue warrants careful reading by every member who daily is faced with the task of processing claims for benefits under the various programs under which the majority of the citizens are now enrolled. The presentation clearly sets forth the differences between the various types of coverage, and explores the disturbing problem of double coverage through which some persons seek to profit on the services of the physician. The recommended procedures set forth by the chairman of the Society's Health Insurance committee offer a realistic approach to the problem, and they may well be adopted by every physician.

Special printed information forms for physicians to distribute to their patients to inform them of the types of insurance coverage available, and thus to educate them to the proper use of their insurance, are available through the Society's headquarter's office. These forms should receive wide distribution in the interests of the voluntary prepayment programs.

BE WATCHFUL

Dr. William B. Cohen in his article in this number on THE USES OF ERYTHROMYCIN IN DERMATOLOGY starts with the statement, "the advent of new drugs and their therapeutic evaluation are a constant challenge to every physician." We fear that the full extent of this statement is not always appreciated. Too many of our practitioners get on the bandwagon and use the new drugs without much discrimination. Therefore, we think it wise to put in a little warning occasionally when reports are made on such drugs.

Last year we had a report of an unusual drug in which the writer put in proper warnings and we reiterated these warnings in the editorial columns. We were indeed glad that we did this for soon there were numerous reports in the literature of the adverse results of the use of this drug.

The profession is beginning to realize now that the relation of drugs and illness may change fairly rapidly. We all know now that some of the antibiotics started off with great efficiency and little danger, while later the efficiency decreases and the danger increases.

It is highly proper to make such a report of benefits as has been made in this article, but let us always keep our fingers crossed as we await new developments in the use of the drug.

WORKMEN'S COMPENSATION LEGISLATION

As this comment is written, the latest version of a workmen's compensation act is before the General Assembly. Its fate is problematical, although recent public reports of a possible compromise between the differing political views of a commission versus a court authority lend hope that the present issue of the legislation may be enacted.

The medical provisions, sections 5 and 21 of Article II in particular, differ from those prepared a year ago in many respects. The new version calls for unlimited payments for medical and hospital care and ancillary services, and it disregards the Society's proposal of a panel of physicians from whom impartial examiners may be chosen.

The medical profession has been the victim of much unfair criticism as regards the costs of the workmen's compensation program in Rhode Island, especially in view of the fact that medical costs are all inclusive and not physicians' fees alone. The Rhode Island Medical Society supported legislation in recent years to effect every possible safeguard of the injured workers' rights, and at the same time offer protection against misuse of the compensation fund for unnecessary health services.

The new bill does offer to establish a medical advisory committee of seven members whose professional pursuits are not set forth in the bill, and who would serve "without compensation in advising and assisting the department of labor in the administration and operation of the workmen's compensation program." We know that advisory committees are not always heeded, even when their advice is sound and reasonably advanced. Yet we are confident that a representative committee of professional men can be appointed who would conscientiously discharge the responsibility set forth in the proposed amended compensation bill.

We for our part have special committees of our Society who have rendered outstanding service to health and welfare agencies throughout the State. We could cite many instances of the efficient help that has been given the state government in resolving medical matters in the best interests of the citizens who receive the care under the various programs. We see in the proposed advisory committee to the workmen's compensation program a safeguard, and not too strong a one in view of the limited authority vested with it, against misuse of the compensation funds in the matter of health care.

PEDIATRIC PROBLEM

Much has been written in recent years of the expanding population of the country. The real

impact of this growth as it pertains to Rhode Island was brought home to us forcefully recently by a flyer from Narragansett Council, Boy Scouts of America, relative to the annual boy crop in this state.

According to the scout statistician the Boy Scout potential population will increase by more than 3,300 in the period from 1955 to 1959, with the annual boy crop of "new potentials" rising from 5,671 to 9,000 within this five-year span. And if that is the picture for the boy crop we may rightly deduce that the female half of the growing population will present a parallel story.

All this presumably indicates that the field of pediatrics will attract more young physicians in the years ahead. Of greater significance at the moment is the necessity for long-range planning to meet the needs of the agencies engaged in child health services, of which the Boy and Girl Scout organizations play major roles. The curtailment of funds for these agencies will necessarily restrict their efforts to carry forward their increasing task to cope effectively with the threat of juvenile delinquency. Their appeal for financial assistance through voluntary or sustaining memberships should be supported.

PHYSICIANS SERVICE

The report of the completion of four years' operation of Physicians Service published in this issue represents a tribute of unusual character to the physicians of Rhode Island. Starting in 1950 Physicians Service, underwritten by the participating physicians, has climbed into the forefront among the voluntary surgical-medical plans of the nation. Only Delaware, with less than half the population of Rhode Island, has enrolled a higher percentage of its people.

In four years' time Physicians Service has enrolled more than 400,000 persons, has paid out more than seven million dollars in benefits, and has operated at one of the lowest costs of any similar program in the country. Our plan has proved the thought projected by President Eisenhower in his health message to Congress that "the best way for most of our people to provide themselves the resources to obtain good medical care is to participate in voluntary health insurance plans."

But the backbone behind the entire Service has been the 810 participating physicians who, as Doctor O'Connell indicated in his address to the Corporation, agreed "to accept the indemnities or such lesser amount as may be deemed necessary . . . to maintain the financial integrity" of the plan. It was the assurance that these physicians of Rhode Island were standing solidly behind the surgical program that gave it the impetus to gain the tremendous enrollment in the short span of four years.

DISTRICT MEDICAL SOCIETY MEETINGS

WASHINGTON COUNTY MEDICAL SOCIETY

At the annual meeting of the Washington County Medical Society the following officers were elected:

President—Richard J. Kraemer, M.D.
1st Vice President—Hartford P. Gongaware, M.D.
2nd Vice President—Sylvester A. Capalbo, M.D.
Secretary-Treasurer—Attilio A. Manganaro, M.D.
Auditor—Chester Solez, M.D.
Censor—F. Bruno Agnelli, M.D.
Delegate—Samuel Nathans, M.D.
Councillor—John P. Jones, M.D.
Alternate Councillor—Hartford P. Gongaware, M.D.

RICHARD J. KRAEMER, M.D., *President*
Washington County Medical Society

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, February 1, 1954. The meeting was called to order by the President, Dr. William J. O'Connell, at 8:30 p.m.

The Secretary reported that the minutes of the previous meeting were to be published in the RHODE ISLAND MEDICAL JOURNAL and, therefore, the reading of them would be omitted unless there was objection. No objection was made and therefore the reading was omitted.

The Secretary read a communication from the Rhode Island Medical Society reporting the action of the House of Delegates in disapproving of any special type listings of physicians' names in the alphabetical sections of telephone or other public directories and also reaffirming its decision of January 23, 1953 that no member of the Society shall list his specialty after his name in the *classified* section of the telephone directory, or in any other non-medical directory, except that when identical last names of physicians *may* be a cause of inconvenience to the public the specialty listing *may* be given.

The Secretary reported briefly on the report of the Rhode Island Medical Society's Committee on Veterans Affairs to the House of Delegates at its January meeting.

The President announced that the committee of Drs. Reginald A. Allen and Walter S. Jones had prepared, and had filed with the Secretary, the Association's tribute to the late Dr. John Francis Murphy; the committee of Drs. Henry S. Joyce and Gustave Pozzi had prepared for permanent file the Association's tribute to the late Dr. William W. Hunt of East Providence. He also announced that the Committee on Arrangements has notified him that Dr. Richard Ford of Boston, Head of the Medical-Legal Department at Harvard Medical School, would discuss "Therapeutic Misadventures" at the March 1st meeting.

The President awarded membership certificates to the following physicians who had been elected to membership at the January meeting of the Association: Paul Barney Metcalf, M.D., and Walter Neil Meisler, M.D.

A motion picture in sound entitled "Rhode Island Fights Cancer" was shown. The film de-

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To All Participating Physicians:

More than 80,000 claims were processed in 1953.

YOU can help the Claims Department and yourself by following these procedures in 1954:

1.

SEND COMPLETE CLAIM FORMS PROMPTLY –

As soon as your patient is discharged.

2.

MAIL CLAIM FORMS DAILY, IF POSSIBLE.

Don't wait until the end of a week or month as the delay puts an undue burden on the Claims Committee, and prevents prompt sending of checks.

Help PHYSICIANS SERVICE to Help You and Your Patients in the matter of Benefit Claims.

PROVIDENCE MEDICAL ASSOCIATION

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picted the program developed by the Cancer Committee of the Rhode Island Medical Society and the Rhode Island Cancer Society in its work in the detection and control of cancer in the state.

The President introduced Mr. Max Cohen, sales manager of the Lifteez Company, who spoke briefly regarding the hydraulic invalid lift made by his company which also is being demonstrated for the physicians in the Library this evening.

The President introduced as the guest speaker of the evening Dr. Lewis Dexter of Boston, Assistant Professor of Medicine, Harvard Medical School; Physician, Peter Bent Brigham Hospital, who spoke on "The Growing Responsibility of the Physician Under an Expanding Program of Cardiac Surgery."

Dr. Dexter talked about the general aspects of cardiac surgery, and in doing so, he reviewed the development of surgery from the discovery of anesthesia to the present time. The surgery of the extremities and amputations was the first type of surgery to be performed. Following this came surgery of the abdomen, surgery of the brain, surgery of the thorax, and lastly, surgery of the heart. He listed the development of cardiac surgery as follows: 1929 Constrictive pericarditis by Dr. Churchill, 1937 Patent ductus arteriosus by Dr. Gross, 1945 Tetralogy of Fallot by Dr. Blalock, 1946 Coarctation of the aorta by Drs. Gross and Crafford, 1944 Foreign bodies by Dr. Harkin, 1948 Mitral stenosis by Drs. Harkin and Bailey, and 1949 Pulmonic stenosis by Dr. Brock.

Dr. Dexter pointed out that the selection of patients for cardiac surgery was extremely important. The factors that should be considered before surgery on any given patient is the disability of the patient and whether or not surgery will accomplish its purpose and the risk involved.

Patients with patent ductus arteriosus are readily cured by surgery, and the risk is less than 1%.

Coarctation of the aorta may be cured, but the risk is greater, approximately 10% mortality.

Patients with Tetralogy of Fallot also present a 10% risk.

The surgery of pulmonic stenosis has a variable degree of risk depending on whether it is the valvular type of stenosis or the infundibular type, the former having the better prognosis.

The surgery of mitral stenosis carries with it approximately 2% mortality.

The surgery of atrial septal defect has not been perfected, but great strides are being made, and the outlook is promising.

The meeting was adjourned at 10:20 p.m.

Collation was served.

Attendance was 78.

Respectfully submitted,
MICHAEL DIMAIO, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

The annual meeting of the Newport County Medical Society was called to order by President Norbert Zielinski at 8:30 p.m., January 27, 1954, in the Hotel Viking with 27 members, and 3 guests, Dr. George Burkley and Dr. Donald Miller of the Naval Hospital and George Castro, encephalographer of Providence.

The speaker of the evening was Captain Robert J. Vaughn, MC, USN, Executive Officer of the Naval Hospital in Newport, who spoke on "Medical Practice in the Soviet Union from 1946 through 1949."

Business Meeting

The minutes of the last meeting were read and approved.

NEW BUSINESS: Dr. Raymond Trott was accepted into membership, and the application of Dr. Thomas Brown was referred to the Board of Censors.

The letter from Mrs. Mary Staples referring to a new community service, based on the science of Metamorphics, was read and discussed and on Dr. Bestoso's motion was referred to the State Society for investigation.

Dr. Dotterer moved that a committee of three be appointed by the president to prepare the medical program and the time and place of the meeting. It was so voted.

Dr. Ceppi moved that the local county medical society as a group, subscribe to the R. I. Physicians Service $14.00 plan with a saving of approximately 20%. This is as contrasted to the $8.00 plan subscribed to through the state medical society. The secretary was directed to contact Physicians Service and initiate such a transfer.

Dr. Caputi reported on Public Relations on the matter of druggists advertising on prescription blanks, stated advertising *per se* is not unethical. After some discussion by Dr. Grimes, who pointed out that it was unfair to the smaller druggist, the problem was considered an individual matter for the doctors.

The following officers were elected:

President: Robert L. Bestoso, M.D.
1st Vice President: John M. Malone, M.D.
2nd Vice President: Edward Zamil, M.D.
Secretary: Jose M. Ramos, M.D.
Treasurer: Donald B. Fletcher, M.D.
Councillor: Samuel Adelson, M.D.
Alternate Councillor: Charles B. Ceppi, M.D.
Delegates: John E. Carey, M.D., Henry W. Brownell, M.D.
Censors: Norman M. MacLeod, M.D., D. A. Smith, M.D.

Dr. Ramos reported the balance in the treasury to be $124.24 to date and that the meals are averaging $3.92 per person.

The meeting was adjourned at 10:30 p.m.

Respectfully submitted,
EDWARD ZAMIL, M.D., *Secretary*

How to control itching and scaling for **1** *to* **4** *weeks*

You can expect results like these with SELSUN: complete control in 81 to 87 per cent of all seborrheic dermatitis cases, and in 92 to 95 per cent of common dandruff cases. SELSUN keeps the scalp free of scales for *one to four weeks*—relieves itching and burning after only two or three applications.

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1-82-54

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Report of the Fifth Annual Meeting of the Corporation, January 20, 1954

THE FIFTH Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service was held at the Rhode Island Medical Society Library, Wednesday, January 20, 1954. The meeting was called to order by the President, Dr. Joseph C. O'Connell, at 8:40 p.m.

The following members of the Corporation were in attendance:

Rocco Abbate, M.D.
Charles J. Ashworth, M.D.
Robert R. Baldridge, M.D.
Irving A. Beck, M.D.
Alex M. Burgess, Jr., M.D.
Frederic J. Burns, M.D.
John E. Carey, M.D.
Wilfred I. Carney, M.D.
Francis H. Chafee, M.D.
William B. Cohen, M.D.
Edmund B. Curran, M.D.
John A. Dillon, M.D.
Michael DiMaio, M.D.
Peter C. Erinakes, M.D.
Charles L. Farrell, M.D.
William J. Fischer, M.D.
Henri E. Gauthier, M.D.
J. Merrill Gibson, M.D.
Russell P. Hager, M.D.
John C. Ham, M.D.
Hannibal Hamlin, M.D.
Herbert E. Harris, M.D.
Albert H. Jackvony, M.D.
Earl F. Kelly, M.D.
Ernest K. Landsteiner, M.D.
Frank J. Logler, M.D.
Edwin F. Lovering, M.D.
Earl J. Mara, M.D.
Robert G. Murphy, M.D.
William S. Nerone, M.D.
Joseph C. O'Connell, M.D.
Thomas Perry, Jr., M.D.
Arnold Porter, M.D.
Alfred L. Potter, M.D.
William A. Reid, M.D.
Lee G. Sannella, M.D.
William J. Schwab, M.D.
Linus A. Sheehan, M.D.
James J. Sheridan, M.D.
Adrien G. Tetreault, M.D.
Henry E. Turner, M.D.
Howard Umstead, M.D.
Francis P. Vose, M.D.
George W. Waterman, M.D.
Harold A. Woodcome, M.D.
Vincent Zecchino, M.D.

Also present were Mr. Edgar H. Clapp, Assistant Executive Director, Mr. J. Lewis Eddy and Mr. George Peterson of the administrative staff, and Mr. John E. Farrell, Executive Secretary.

Address of the President

Dr. Joseph C. O'Connell, President of the Corporation, delivered his annual address reviewing the progress and development of Physicians Service. His address is made part of the official minutes of the meeting.

Annual Report of the Secretary

Dr. Ernest K. Landsteiner, Secretary, read his annual report high-lighting the activities of the work of the Board of Directors throughout the year and of the program of Physicians Service. The report is made part of the official minutes of the meeting.

Action—It was moved that the report of the Secretary be received and placed on file. The motion was seconded and adopted.

Annual Report of the Treasurer

Dr. Charles J. Ashworth, Treasurer, reviewed the financial status of Physicians Service at the completion of its fourth year of operation. He reported that the total net income for the year was $3,362,551.52, of which $2,486,094.49 was paid to Participating Physicians and $498,221.01 to non-Participating Physicians, making a total of 88.8% expenditures.

He noted that the total operating expenses were $210,311.60, representing 6.2% of the net income. The 5% balance amounted to $167,924.42, which has been added to the reserves.

Dr. Ashworth also reported that the invested funds held for the Corporation by the Providence Union National Bank and Trust Company totaled more than $896,000, and had earned approximately $20,000 in dividends in 1953.

Action—It was moved that the report of the Treasurer be received and placed on file. The motion was seconded and adopted.

Nominations for Board of Directors

The Secretary reported that the House of Delegates of the Rhode Island Medical Society had nominated, to serve for three-year terms as members of the Board of Directors of Physicians Service, the following:

Rocco Abbate, M.D., Kent
Frank B. Cutts, M.D., Providence
Orland F. Smith, M.D., Providence
Earl J. Mara, M.D., Pawtucket

Action—It was moved that the physicians nominated by the House of Delegates be elected by the Corporation. The motion was seconded and adopted.

Adjournment

The business of the Corporation completed, Dr. O'Connell declared the meeting adjourned at 9:05 p.m.

Respectfully submitted,
ERNEST K. LANDSTEINER, M.D., *Secretary*

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PHYSICIANS SERVICE

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Annual Report of the Secretary

The Board of Directors of Physicians Service has held five meetings since the 4th Annual Meeting of the Corporation to transact the business of the Corporation in the continuing expansion of the program.

At its annual meeting in 1953 the Board elected as officers of the Rhode Island Medical Society Physicians Service the following:

Joseph C. O'Connell, M.D. ..... *President*

Rocco Abbate, M.D. ..... *Vice-President*

Ernest K. Landsteiner, M.D. ..... *Secretary*

Charles J. Ashworth, M.D. ..... *Treasurer*

As representatives of the public on the Board the following were elected:

Mr. Walter F. Farrell, Pres., Prov. Union Nat'l Bank & Trust Co.

Mr. John Shepard, II, of the Shepard Company

Mr. George R. Ramsbottom, Pres., Seekonk Lace Company

Mr. James R. Donnelly, Mgr., Pawt. Branch, R. I. Hosp. Trust Co.

During the year Mr. Shepard tendered his resignation owing to his many other business obligations, and the Board elected Mr. John J. Halloran, commercial superintendent of the New England Telephone & Telegraph Company, to fill Mr. Shepard's unexpired term.

Elected to the Board as additional public representatives were the two nominees of the Hospital Service Corporation of Rhode Island—Mr. Emil E. Fachon, President of the Bulova Watch Company, and Mr. Felix A. Mirando, Secretary-Treasurer of the Imperial Knife Company.

In accordance with the By-Laws, the Board of Directors named sub-committees that have actively carried on many phases of the operation of the Physicians Service program. A standing committee on claims was also named, and this committee has met continuously throughout the year to review all claims not readily established under the Master Schedule of Indemnities.

A revised letter was prepared and sent to every subscriber who received benefits under the program, and all replies critical of any phase of the program were promptly investigated and answered by the president or the executive secretary.

The Board of Directors initiated a study aimed towards possible revision of the Master Schedule of Indemnities, and it also authorized a cost analysis of Physicians Service to be undertaken by Ernst & Ernst. The Rhode Island Medical Society was also asked to re-activate its study committee to review the fees listed in the Schedule of Indemnities for the purpose of determining any inequities.

The Board approved of a direct enrollment campaign which resulted in 15,892 subscribers being enrolled, and made our program one of the few in the country offering the coverage to any person of any age, whether employed or not.

Appended to this report, and made a part of it, is a comparative summary of the years 1952 and 1953 as prepared by the executive director.

Respectfully submitted,

ERNEST K. LANDSTEINER, M.D., *Secretary*

Rhode Island Medical Society Physicians Service—Comparative Data

	Year 1952		*Year 1953*
Subscribers	314,560	Increase 85,527	400,087
% Blue Cross Direct Payment Members	44.2%	Increase 14.5%	58.7%
% Blue Cross Group Members Enrolled	55.4%	Increase 13.5%	68.9%
% State's Eligible Population Enrolled	42%	Increase 8.5%	50.5%
Number of Firms Buying Physicians Service	425	Increase 150	575
Amount Paid to Participating Physicians	$2,068,922.00	Incr. $399,172.49	$2,486,094.49
Amount Paid to Non-Participating Physicians	$469,304.17	Incr. $28,916.84	$498,221.01
Total Paid to Physicians Since Start of Plan	$4,092,441.67	Incr. $2,984,315.50	$7,076,757.11
Number of Participating Physicians	770	Increase 40	810
Total Assets	$1,246,275.87	Incr. $303,257.99	$1,549,533.86
Investments	$697,950.22	Incr. $198,554.69	$896,504.91
Total Income	$2,846,416.19	Incr. $516,135.33	$3,362,551.52
Total Reserves	$367,081.88	Incr. $82,572.42	$449,654.30
Reserve for Maternity Benefits	$302,018.00	Incr. $85,352.00	$387,370.00
Operating Expenses	$167,463.24	Incr. $42,848.36	$210,311.60
% Income for Operating Expenses	5.9%	Increase .3%	6.2%
% Income for Claims	89.2%	Decrease .4%	88.8%
Total Cases Processed	65,100	Increase 15,293	80,393
Maternity Cases*	5,782	Increase 1,926	7,708

*Included in total cases.

THE PROBLEM OF THE FOREIGN-TRAINED DOCTOR

Highlights of a Summary Report from the AMA on the 50th Annual Congress on Medical Education and Licensure

LICENSURE and medical care problems created by the heavy influx of foreign-trained doctors commanded a great deal of attention at the 50th annual Congress on Medical Education and Licensure February 7-9 at Chicago. The three-day meeting attracted an unexpectedly heavy attendance of more than 600 medical educators and licensing and specialty board officials. The congress was sponsored by the American Medical Association's Council on Medical Education and Hospitals, the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties.

"The infiltration of the medical profession of the United States by large numbers of doctors who have not been able to obtain a proper basic professional education is almost certain to lower the general level of practice in this country," Dr. Willard C. Rappleye, New York, dean of Columbia University College of Physicians and Surgeons, told the meeting.

"The numbers coming in are so large that they cannot readily be absorbed without that effect."

Dr. Rappleye pointed out that the United States government, in fostering international good will, is admitting large numbers of displaced persons, including physicians about whose professional ability no questions are asked. More will be admitted by recent legislation which permits the entrance of several hundred thousands of immigrants above previous quotas, he said.

He added that unless this situation is met "with courage and the conviction that we shall not surrender the results of forty years of effort in raising the standards of medical licensure, practice and education," we may revert to conditions resembling those of fifty years ago.

Dr. Stiles D. Ezell, Albany, secretary of the New York Board of Medical Examiners, also called attention to the inadequacy of the medical training of most of the foreign doctors seeking to practice in the United States.

Dr. Ezell said that except for Great Britain and the Scandinavian countries the last war brought destruction and degeneration to European medical education.

"Even before the elimination of the last of the unapproved medical schools in this country, there had begun a migration of physicians to this country which has now reached a total of more than 20,000," he stated. "The challenge in this fact is that the profession has not been prepared to understand what is involved in such a massive movement, nor has it realized the numerous deficiencies involved in the collective educational background of this group."

He pointed out that large numbers of foreign graduates have completed specialized training without any consideration of the deficiencies in their basic medical training or their eligibility for licensure.

Dr. Edward L. Turner, Chicago, secretary of the Council on Medical Education and Hospitals, recommended the adoption of a uniform plan for screening the professional competence of foreign-trained doctors.

Such a uniform procedure, Dr. Turner said, would be of greater assistance to state medical licensing boards than the present attempts to evaluate and list foreign medical schools. He pointed out that there are problems and difficulties in evaluating foreign medical schools which are "almost insurmountable."

Dr. Turner reported that the Council on Medical Education and Hospitals and the executive council of the Association of American Medical Colleges have compiled a list of 39 foreign schools which provide basic medical education on a par with that of approved schools in the United States, but said there are more than 550 medical schools in the world.

He said that while the council has endeavored to indicate that the absence of a school from this current listing does not indicate either approval or disapproval, but means primarily lack of adequate information, the absence of listing frequently serves to deny a graduate the right to examination before a state board.

"It seems advisable that there should be a careful analysis of state medical practice acts with serious consideration being given to the cooperative development of some commonly acceptable yardstick or screening mechanism to evaluate competence of the foreign graduate," Dr. Turner stated.

CONTROL OF ALCOHOLISM IN RHODE ISLAND

An Abstract of the 1952-53 Annual Report of the Division of Alcoholism of the Department of Social Welfare of Rhode Island

C. H. CRONICK, M.D., *Administrator of the Division*

FISCAL 1952-53 marked the first continuous year of operation of the Division of Alcoholism, completing a total of twenty-one months of existence of the Division. Concentration on the development of the Day Clinic facilities at 94-98 Doyle Avenue, Providence, resulted in an expansion from three to nine beds. This clinic is operated on a principal similar to the Montreal Psychiatric Day Clinic.

Patients are admitted early in the morning, spend the day receiving medical, psychiatric, and social supervision, return home during the night on prescribed continued medication, only to return the next morning (and the next if necessary) to complete the withdrawal regime. Thus, the addiction cycle of the alcoholic is broken and he and the clinic are prepared by material gained during these first few days with a frame of reference from which to plan subsequent treatment.

A total of 868 new admissions to the Division were achieved during this fiscal year. These patients made an average of 5.6 visits to the clinic for various services. 437, slightly more than half the number of patients seen at the clinic, received withdrawal treatment in the Day Clinic. 74% of these patients achieved withdrawal in the maximum of three days. Of the 26% who failed to achieve withdrawal, approximately half were admitted to the State Hospital for Mental Diseases, at which time withdrawal was completed, and the other half continued to drink. Of the 293 patients who received withdrawal, 70 relapsed once; 51 relapsed twice; 12 relapsed three times; 9 relapsed four times; 7 relapsed five times; 3 relapsed six times; 1 relapsed nine times. Each of these succeeded in repeated withdrawal attempts.

It is the policy of the Day Clinic not only to achieve withdrawal from alcoholism, but to begin obtaining social and medical histories from which individual or group psychotherapy may proceed. Naturally, with the case load so huge, it is impossible to think of a high percentage of individual therapy. Individuals are always seen alone the first time and occasionally for one or two more times. At this point they are usually assigned to group follow-through.

Psychiatric Follow-up

For the purpose of providing psychiatric follow-up treatment during the year (there were as many as seventeen separate groups), 342 patients received group therapy, making an average number of 5.6 visits per patient. It was noted that not only did the problem of numbers resolve itself through this therapy, but the patients themselves were less resistive under group therapy than individually. Problems that ordinarily would have taken many months to bring to the point of discussion in individual therapy would frequently be brought into the open and discussed and resolved in the group in the early stages. These groups were a powerful therapy medium, as members of A.A. have discovered long ago.

In-patient services continued at the State Hospital for Mental Diseases. Primarily these were limited to those who failed to achieve a withdrawal, or those referred by an agency or hospital on off-clinic hours, and who were felt to be so physically ill that immediate attention was imperative. It was, and is our policy to limit these admissions to the State Hospital to periods essential for withdrawal only. We feel that it is definitely a mistake to allow a prolonged hospitalization with the resulting increase in the dependencies which develop. A total of 177 new patients were admitted to the State Hospital facilities this year as compared with 225 last year. This represents a sizable drop considering a full fiscal year is reported in the lower figure. In general, our policy is away from hospitalization.

Aid to Courts

Services continued to be rendered to the courts and jail under Chapter 2818 of the Public Laws as amended in 1951. All individuals before sentence as common drunk were examined and recommendation made as to whether they should be committed to the State Hospital or remain in jail. Many cases were recommended a probation period in lieu of either. For those who remained in jail, Dr. Lindberg continued regular weekly group therapy sessions at the jail. 151 patients at the jail received group therapy for a total number of 1043 interviews on a group basis. This compares with 1914 interviews at the Day Clinic.

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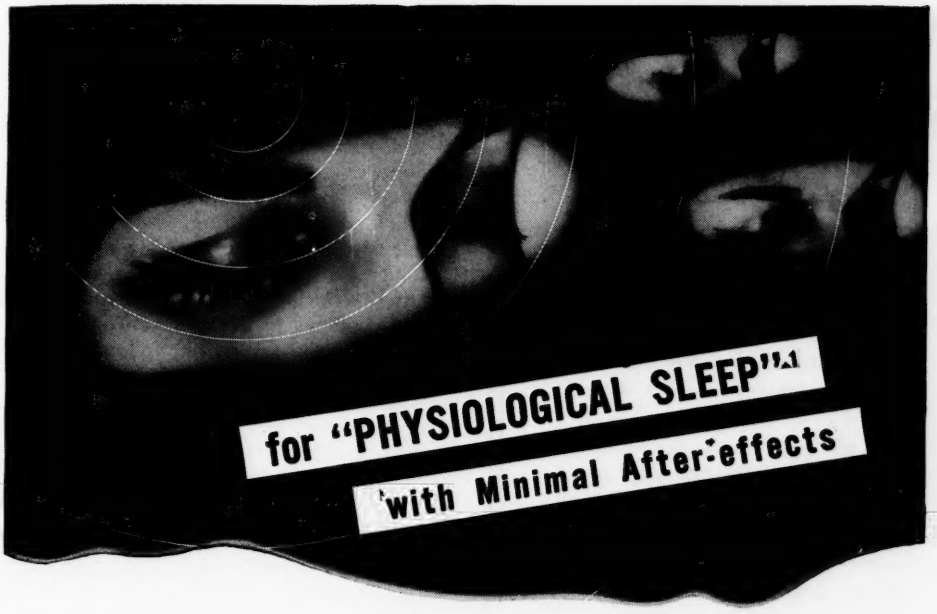


Chloral hydrate, used in medicine since 1869, is, even today, "the standard hypnotic of its class."[1]

Goodman and Gilman observe that it "is unfortunately neglected today," and that the present widespread use of the barbiturates has ". . . caused the physician to lose sight of the fact that chloral hydrate is still one of the cheapest and most effective hypnotics."[2]

In FELLO-SED, supplementation with calcium bromide and atropine sulfate largely overcomes unwanted side-actions, enhances the sedative effect and provides valuable antispasmodic activity. It is presented in palatable liquid form.

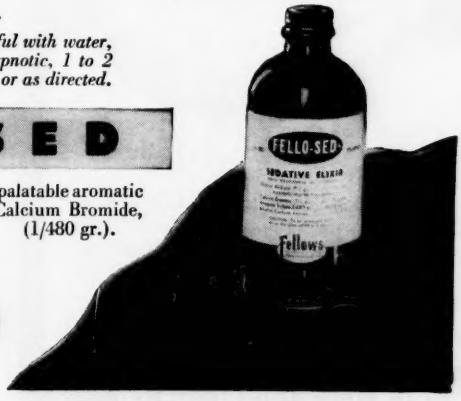
[1]N.N.R., 1947, p. 398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

Available in 8 fluidounce bottles.

Adult Dose: As a sedative: ½ to 1 teaspoonful with water, every 3 or 4 hours or as directed. As a hypnotic, 1 to 2 teaspoonfuls or more with water at bedtime, or as directed.

FELLO-SED

FORMULA: Each fluidram (4 cc.) contains, in a palatable aromatic vehicle: Chloral Hydrate, 0.5 Gm. (7½ gr.); Calcium Bromide, 0.5 Gm. (7½ gr.); Atropine Sulfate, (1/480 gr.).



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CONTROL OF ALCOHOLISM

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Of the total of 868 new cases 12% were women. The total of cases seen to date is 1365. Of this total only 431 were considered active cases as of June 30, 1953, representing 31.6%. In other words, only about a third of the patients originally seen continued active under treatment. This represents a policy of allowing the patients to select themselves for such treatment. In almost all clinics there is an intensive selectivity of cases for such intensive treatment, so that considerably less than one-third are given service by the various divisions throughout the country. In this clinic anyone may appear for treatment and whether he follows through with treatment or not depends on himself. The end results have been that those who have shown a sincerity in wanting to recover would not have necessarily been chosen for such treatment. For the present at least, our policy for services will continue giving each individual a chance to prove his own interest in gaining sobriety.

Follow-through Therapy

Follow-through therapy is not confined to the regular group therapy or individual therapy provided at the clinic. Every patient is given an Alcoholics Anonymous interview by a staff member who is responsible for arranging an initial introduction to an A.A. group through a regular sponsor. The clinic does not follow-up on these cases respecting the anonymity of the A.A. organization. Whenever an individual prefers to achieve his therapy through A.A. alone this permission is granted, and many times his name turns up in the lapsed list only to discover that he is doing well through outside A.A. therapy.

Lists of effectiveness of treatment are to date impossible to evaluate. As noted in the dry-out clinic statistics relapse rate is high in the early stages of treatment. It is presumed at the present state of our knowledge that constant repeated attacks on the over-all problems is the only way of arriving at a successful conclusion. Our philosophy at present is to consider alcoholism as a disease with the chronicity and tenacity of tuberculosis in which relapse must be considered part of the course in the early stages of treatment. It was originally cited that at least a three-year period should be considered essential for medical evaluation of final results. Many problems are presented in evaluating these results inasmuch as a high percentage of patients lapse from the clinic rolls only to be discovered doing well on their own through a regular monthly follow-up of these cases. On the other hand, many of the active cases are known repeated relapsers, presenting serious social and medical problems.

A final word about the withdrawal regime as utilized at the clinic. Patients are given routinely

chlorate and glucose replacement along with adrenal cortical extract. They are routinely also given intensive vitamin replacement. This is based on regimes established by Block in Buffalo, Tintera & Lovell in New York, McAllister in Virginia, etc. This treatment follows the general observation that the withdrawal syndrome presents a condition closely related to that of Addison's Diseases with markedly disturbed chloride balance and shock-like manifestations. This condition responds readily to the adrenal cortex replacement along with adequate electrolytes. General symptomatic treatment is also given depending on the situation presenting itself. If serious organic disease is discovered, referral to physicians and hospital facilities is made, depending on the economic status of the individual. A policy of referral of individuals to their own physicians and to psychiatrists of their own selection for individual treatment has been inaugurated, but has so far been rather inadequate usually due to economic problems.

Fiscal 1952-53 represented a drop in the monthly new admission rate, noticeable toward the latter half which we interpret as a falling off in the number of cases prepared for receiving treatment. It is the present occupation of the clinic to concentrate on a case-finding educational program and crystallization of these features is now in process of working out. It is hoped that the treatment *per se* will fall more and more to the physicians of their choice, with the agency acting in a greater educational capacity with less concentration on treatment *per se*. The reservoir of alcoholics is so great that no one agency could possibly bring all individuals under control without extensive cooperation through other agencies, public and private.

APRIL 5

Providence Medical Association meets at 8:30 p.m.

PROVIDENCE MEDICAL ASSOCIATION

ANNUAL REPORTS — 1953

ANNUAL REPORT OF THE SECRETARY

The Association has completed a very successful year of service to the membership, as well as to the people of the community. Outstanding scientific programs have been presented at the monthly meetings held at the Medical Library, and the various committees have worked on many health and welfare projects developed both by the Association and the Rhode Island Medical Society.

Membership totals are the highest in history, with 578 active members and 61 associate members. During 1953, 33 new members were elected to active membership.

The Medical Bureau completed its fourth year of operation as probably the largest and most complete telephone-secretarial service in the East maintained entirely under the direction of a medical association. Direct loops are listed at the Bureau for 291 members, and twelve operators maintained round-the-clock duty for the physicians, as well as for assistance to the public in securing emergency medical services.

The Annual Dinner and Golf Tournament was the most elaborate ever attempted, and many features were presented through the courtesy of the Charles Pfizer Company of Brooklyn.

The monthly scientific lectures have been well attended, and have been excellently presented. An innovation in connection with the meetings adopted in 1953 was the arranging of a technical exhibit at some of the sessions for the convenience of physicians as well as to aid some pharmaceutical companies unable to display at the state medical society's annual meeting. A summary of the meeting programs is as follows:

January 5—Presidential Address, Frederic J. Burns, M.D. "Positive Biological Forces in Surgical Convalescence," Francis D. Moore, M.D., of Boston, Massachusetts, Moseley Professor of Surgery, Harvard Medical School; Surgeon-in-Chief, Peter Bent Brigham Hospital.

February 2—"Sulfonamides and Penicillin in the Control of Rheumatic Fever in Children," Banice Feinberg, M.D., Visiting Pediatrician, Rhode Island Hospital; Physician-in-charge, Crawford Allen Memorial Hospital; Clinic Physician, Rhode Island State Rheumatic Fever Program. "Medicine at the Department of Defense Level," Melvin A. Casberg, M.D., of Washington, D. C., Chairman, Armed Forces Medical Policy Council, Office of the Secretary of Defense.

March 2—"The Indications and Contraindications for the Use of Blood and Blood Fractions," Louis K. Diamond, M.D., of Boston, Massachusetts, Associate Professor of Pediatrics, Harvard Medical School; Director of the Blood Bank and Research Hematology Laboratory, Children's Medical Center, Boston, Massachusetts.

April 6—"Suicide"—"Some Clinical Aspects," Norman L. Loux, M.D., Clinical Director, Butler Hospital, Providence. "Medicolegal and Pathological Aspects," Arthur E. O'Dea, M.D., Research Fellow in Pathology and Legal Medicine, Department of Legal Medicine, Harvard Medical School.

October 5—Clinical-Pathological Conference—Moderator, Alex M. Burgess, Sr., M.D., Area Division Chief in Medicine, U. S. Veterans Administration; Clinical Discussers: Ivan L. Bennett, Jr., M.D., Assistant Professor of Medicine, Yale University Medical School and F. Dennette Adams, M.D., Assistant Clinical Professor of Medicine, Harvard Medical School; Physician, Massachusetts General Hospital; Pathologist, Jacob Dyckman, M.D., Director of Laboratories, Miriam Hospital, Providence.

November 2—"The Genesis of Uterine Carcinoma, Endometrial and Cervical," Arthur T. Hertig, M.D., Shattuck Professor of Pathological Anatomy, Harvard Medical School; Consultant Pathologist to Boston Lying-In Hospital and Free Hospital for Women, Boston.

December 7—"Use of Chemical Agents in the Relief of Pain," Henry K. Beecher, M.D., Dorr Professor of Research in Anesthesia, Harvard Medical School; Anesthetist-in-Chief, Massachusetts General Hospital.

The total membership of the Association at the end of the year was 639, of whom 61 were associate members, for the most part physicians who hold active membership in other district medical societies in Rhode Island and who also desire to participate in our Association's activities. During 1953, 33 physicians were elected to active member-

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REPORT OF SECRETARY

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ship, 5 to associate membership, 1 member was reinstated as an active member, 1 resigned from active membership, and 1 transferred from active to associate membership.

During 1953 the Association lost five physicians by death, as follows:

Francis D. O'Connell, M.D. (Jan. 9, 1953)
Hugh J. Hall, M.D. (June 20, 1953)
John F. Murphy, M.D. (August 30, 1953)
Tancredi G. Granata, M.D. (Sept. 17, 1953)
William W. Hunt, M.D. (Dec. 18, 1953)

* * *

Your Secretary notes the completion of his third term of office with appreciation to the members of the Association for their cooperation throughout the year, and to the staff of the executive office for their valuable assistance.

Respectfully submitted,
MICHAEL DIMAIO, M.D., *Secretary*

ANNUAL REPORT OF THE TREASURER

RECEIPTS		
Dues	$10,125.00	
Interest on investments	60.00	
Exhibits	200.00	
Annual dinner payments	735.00	
Total	$11,120.00	
Cash Deficit, Jan. 5, 1953	267.34	
Net Receipts, 1953		$10,852.66
EXPENSES:		
Collations	$ 420.00	
Committees	182.92	
Annual dinner	776.25	
Donations to R. I. Med. Soc., use of bldg. and services	2,430.56	
General expenses	861.31	
Journals	512.95	
Meetings	428.68	
Office supplies and equipment	668.80	
Postage and printing	637.25	
Repairs (bldg.)	250.00	
Salaries	1,887.20	
Taxes	493.70	
Telephone	283.89	
Total		$ 9,833.51
Cash Balance, January 4, 1954		1,019.15
Investments—Government bonds		2,700.00
Total assets, January 4, 1954		3,719.15

ROBERT G. MURPHY, M.D., *Treasurer*

ADVISORY COMMITTEE TO THE COMMUNITY WORKSHOPS, INC.

One meeting of the full Committee was held jointly with members of the staff of the Community Workshops. The Chairman and individual members of the Committee have met at various times with officers and committees of the Community Workshops.

It is felt that your Committee performed a useful function as advisors to the Community Workshops.

Respectfully submitted,
CLIFTON B. LEECH, M.D., *Chairman*

PROGRAM COMMITTEEE

The Committee has met two or three times during the past year to consider programs for this season. In general, the same plans were followed in relation to the programs as were in effect in the previous two years.

Meetings have been reasonably well attended and well received.

This year one innovation was introduced in the form of a clinical-pathological conference involving a moderator, two clinical discussers and a pathologist. This meeting opened the 1953 season and was sufficiently well received to justify consideration in subsequent years.

Respectfully submitted,
ALEX. M. BURGESS, JR., M.D., *Chairman*

COMMITTEE ON LEGISLATION

This Committee has held two meetings during the year in conjunction with the State Committee on Legislation and all matters pertaining to the medical profession or of interest thereto, introduced at the State, were thoroughly gone into. The Committee was greatly assisted in its deliberations by the splendid abstracts prepared by John E. Farrell, our Executive Secretary.

Respectfully submitted,
JOSEPH SMITH, M.D., *Chairman*